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Views Expressed to the I.H.S. Restructuring Initiative Workgroup

Possible Preliminary Recommendations:

GOVERNMENT TO GOVERNMENT RELATIONSHIP

(a) The I.H.S. and the Secretary of DHHS must recognize the sovereignty of the American Indian and Alaska Native tribal governments, honor the government to government relationship established in federal law and through treaty obligations, and respect this relationship in any process of re-designing federal health programs affecting Alaska Natives and American Indians

(b) The Secretary of DHHS must fulfill the Department's policy requiring full, comprehensive consultation with tribal governments in any process of re-designing federal health programs affecting Alaska Natives and American Indians. To date the Department's initiatives have not been subject to such formal consultation.

(c) The Secretary's One-DHHS initiative may have benefits in reducing federal bureaucracy and' creating efficiencies at the Departmental level; however, these efficiencies must not be achieved at the expense of the resources and capabilities of the Indian Health Service and tribal/urban Indian health programs.

(d) The Indian Health Service has a unique responsibility, unlike any other agency within the Department of Health and Human Services. It is responsible for fulfilling the federal government's trust obligation to tribal governments; 50% of the I.H.S. direct services program is now managed, by tribal governments through self governance agreements. It is significantly different from the CDC, CMS, FDA, N and other DHHS agencies.

(e) Tribal leaders believe that the most significant restructuring of DHHS that will benefit Alaska Natives and American Indians would be the elevation of the position of the Director of the Indian Health Service to the level of Assistant Secretary for Indian Health within the Department.

OVERALL I.H.S FUNDING

(1) The Indian Health Service Level of Need Funded process has determined that the agency's recurring services budget would need to be increased from the current level of $2.5 billion to $15 billion in order to fully meet health care needs of both the 1.5 million Al/AN currently served by the Indian Health Service and the 1 million off- reservation Al/AN not currently served by the agency.

The unmet needs list for Indian Health facilities identifies the need for at least $1 bfflion in sanitation facilities construction in Indian communities and the need for $1 billion in construction of the new and replacement hospitals, health centers, staff quarters, and residential treatment facilities in Indian communities currently on the 1.11.5 . priority list. The full requirement for all needed facilities remains to be determined.

The Administration and the DHHS should set the same objective for the Indian Health Service that it has for the National Institutes of Health: the doubling of the agency's budget over a five-year period.

To the extent the I.H.S. budget is not sufficient to meet the full need for Al health care, the Indian Health Service and the Department of Health and Human Services need to be structured and resourced sufficiently provide technical assistance to tribal governments and tribal organizations enabling them to access other DHHS resources outside of the Indian Health Service to meet their needs.

ONE-DHHS INITIATIVE

(g) Tribal leaders believe that the Indian Health Service should be exempted from several of the One-DHHS initiatives proposed by the Secretary. These exemptions should be based on the unique status of the Indian Health Service.

Legislative and Public Affairs

The I.H.S. legislative office should not be consolidated with the DHHS legislative liaison office. This office provides a critical liaison between the Congress, the I.H.S. administration, the DHHS administration, and tribal governments. To be most effective this office must be closely connected with the I.H.S. administrative offices. The relationship of the Indian Health Service with the Congress is unique within the DHHS, with separate appropriations processes and oversight committees.

The I.H.S. Public Affairs office should not be consolidated with the IMIIIS public affairs office. Reasons?????

Indian Health Facilities

The Indian Health Service health facilities program one of the few DHHS agencies with a direct health care delivery mission, and has unique health facility requirements. These requirements deserve a specific focus, connected to this mission and to the specific program objectives of the agency. Tribes, Congress, and the Indian Health Service have developed detailed processes for ascertaining facility needs, identifying priorities for Al/AN health facilities construction, and for determining methods for financing, design, construction and maintenance of such facilities that are tailored to the unique challenges in this operating environment.

Consolidating Indian health facilities management into the Du health facilities management process would unnecessarily complicate these processes. These activities should remain within the Indian Health Service as currently structured.

If the Secretary requires more information concerning I.H.S. facilities status and issues than has traditionally been provided, there should be regular reporting to appropriate individuals at the department level.

Information Technology:

* [pending recommendation from the Information Systems Advisory Committee at the next RIW meeting

FTE Reductions:

Between 1993 and 2001 the Indian Health Service made significant reductions in administrative positions and increased staff positions at the service delivery level:

Location	1993	2001	NET
Headquarters	937 FTE	379 FTE	-558
Area Offices	2705 FTE	1,146 FTE	-1559
Service Units	11752 FTE	13106 FTE	+1354

In summary Headquarters and Area Office FTE's have been reduced by nearly 60%. The current ratio of HQ/Area positions to Service Unit positions is down to 1:10.

The agency cannot afford to make an additional reduction of 100 FTE's in administrative positions at HQ/Area levels without significantly impacting the ability of the agency to operate in an effective and responsible manner.

The Indian Health Service has made reductions in administrative staffing over the past eight years that far exceed any reductions made in any other DHHS agency. The Department should recognize this progress and require other agencies to make similar reductions before imposing additional FTE reductions on the Indian Health Service.

Conversely, Tribal leaders contend that the overall staffing level of the I.H.S. (including the tribal and urban programs operating under self governance and self-determination agreements) should be increased from 15,000 to 30,000 over the next five-year period.

Human Resources Management

[recommendations yet]

Financial Management

[recommendations yetj

OTSG Staffing

Since 1993 the number of self-governance tribes has increased substantially; in FY2002 approximately 50% of the funds appropriated to the Indian Health Service are managed by tribes and tribal organizations under the terms of FL. 93-638.

The staffing resources for the Office of Tribal Self-Governance has not kept pace with this rapid increase in self-governance agreements. Restructuring of the Indian Health Service should include an appropriate increase in staffing and associated resources available to the Office of Tribal Self-Governance.